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1. Initial Straw Poll Results

This document provides the results of the *CAQH CORE Code Combinations Task Group Initial Straw Poll on Potential Compliance-based Adjustments and Market-based Adjustments to the CORE Code Combinations v3.7.4 June 2023.* More information about the potential compliance-based and market-based adjustments considered by the task group can be found here.

2. Respondent Breakdown

16 organizations responded to the CCTG ISP, representing **64%** of the Task Group's membership. The breakdown of respondents by stakeholder type is shown Table 1.

Table 1: Responses from Task Group Participating Entities by Number and Entity Type

Number of Active* Task Group Participating Entities	25
Total Number of Individual Organizational Responses	**16 (64%)**
Number of Health Plan/Health Plan Association Responses	**6 (44%)**
Number of Provider/Provider Association Responses	**1 (6%)**
Number of Vendor/Clearinghouse Responses	**2 (12%)**
Number of Government Responses (State Medicaid Agencies, etc.)	**3 (19%)**
Number of Other Stakeholder Type Responses (SDO/Regional Entities, etc.)	**3 (19%)**

***NOTE**: Active participants attended most Task Group calls and responded to most Task Group Straw Polls for the last 5 Compliance-based Reviews.

3. Overview of Results for CBR/MBR Initial Straw Poll

Support for each code combination considered as part of the compliance-based and market-based adjustment reviews is shown below. Code combinations receiving >65% from the task group are recommended by CAQH CORE staff and the CCTG Co-chairs for adjustments to the CORE Code Combinations, whereas those combinations receiving <65% support are not recommended for addition.

Detailed descriptions and anonymized comments are included in the Appendix, in Tables 6 and 7 for CBR results and Tables 8 and 9 for MBR results.

4. Polled CBR Code Combinations

CBR polling based on newly published RARC N887 and re-polled RARCs N880 and N881.

Table 2: Polled CBR Code Combinations Receiving >65% Support for ADDITION to the *CORE Code Combinations*

Proposed TO BE **ADDED** to the *CORE Code Combinations*. *Breakdowns of responses by stakeholder types and detailed CARC and RARC descriptions are in the APPENDIX*.

Line	Support	Business Scenario	CARC	RARC	CAGC	Comments for	Comments against
1	67%	3	**96** Non-covered charges	**N887** Providers in MA plan have right to appeal.	CO, PI, or PR	N/A	Multiple organizations believed that this N887 is more of an alert RARC and does not provide value in a combination. One respondent disagrees with the addition of CAGC PR to this combination.
2	81%	3	**96** Non-covered charges	**N881** Client Obligation, patient responsibility for Home & Community Based Services.	CO, PI, or PR	N/A	Questioned if the only CAGC applied should be PR.. One respondent noted that RARC N881 is specific to Medicaid, and is more appropriate to pair with CARC 142 ADD DEFINTION

Table 3: Polled CBR Code Combinations Receiving <65% for ADDITION to the *CORE Code Combinations*

Proposed to **NOT BE ADDED** to the *CORE Code Combinations*. *Breakdowns of responses by stakeholder types and detailed CARC and RARC descriptions are in the APPENDIX.*

Line	Support	Business Scenario	CARC	RARC	CAGC	Comments for	Comments against
1	0%	2	**16** Claim/service lacks information or has submission/billing error(s)	**N887** Providers in MA plan have right to appeal.	CO or PI	N/A	Multiple organizations believed that RARC N887 is more of an alert RARC and does not provide value in this combination. Additionally, it is too narrowly applied.
2	62%	3	**197** Precertification/authorization/notification/pre-treatment absent.	**N887** Providers in MA plan have right to appeal.	CO, PI, or PR	N/A	One organization responded that the CAGC PR is inappropriate for inclusion with this code combination.
3	50%	2	**16** Claim/service lacks information or has submission/billing error(s)	**N880** Original claim closed due to changes in submitted data.	CO or PI	N/A	One organization stated that RARC N880 does not provide additional information regarding the missing data or error.
4	54%	2	**129** Prior processing information appears incorrect.	**N880** Original claim closed due to changes in submitted data.	CO or PI	N/A	One organization believes that the code combination does not directly state additional information is needed and implies action is already taken.

5. Polled MBR Code Combinations

Table 4: Polled MBR Code Combinations Receiving >65% Support for ADDITION to the *CORE Code Combinations*
Proposed **TO BE ADDED** to the *CORE Code Combinations*. *Breakdowns of responses by stakeholder types and detailed CARC and RARC descriptions are in the APPENDIX.*

Line	Support	Business Scenario	CARC	RARC	CAGC	Comments for	Comments against
1	*93%*	*3*	***95*** *Plan procedures not followed.*	***N79*** *Service billed is not compatible with patient location information.*	*CO, PI, or PR*	*N/A*	*One respondent noted that this combination does not provide any additional information and a better understanding of patient location is necessary.*
2	*79%*	*3*	***96*** *Non-covered charges.*	***N79*** *Service billed is not compatible with patient location information.*	*CO, PI, or PR*	*N/A*	*N/A.*
3	*85%*	*3*	***185*** *The rendering provider is not eligible to perform the service billed.*	***N448*** *This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.*	*CO, PI, or PR*	*N/A*	*N/A*

6. Overview Straw Poll Write-ins

Respondents wrote in potential code combinations for consideration of addition to the CORE-required Code Combinations. These code combinations are pairings between the newly published **RARC N887** within the four CORE-defined Business Scenarios. Each is briefly described below with detailed descriptions included in Table 4 in the Appendix. Note, in accordance with CORE Code Combinations Evaluation Criterion #17. CAGCs would be included in accordance with the associated CARC's CORE-defined Business Scenario.

7. Write-in Code Combinations

Proposed CARCs to be combined with the newly published **RARC N887**: *Providers not participating in the Medicare Advantage Plan have the right to appeal if the plan has partially or fully denied payment or if the provider believes the plan has not paid the services at the expected Medicare reimbursable rate or type of level/service. Providers may file their appeal in writing within 60 calendar days after the date of the remittance advice. For the plan to review the appeal, the plan will need a completed signed Waiver of Liability Statement. To obtain a Waiver of Liability form, please contact your Medicare Advantage Plan. Once we receive the completed forms, we will give you a decision on your appeal within 60 calendar days.*

Table 5: Write-in CARCs to be Combined with Newly Published RARC N887

Line	Business Scenario	*CARC*	*CARC Description*	*ASC X12 CAGC*
1	3	95	Plan procedure not followed	CO, PI, or PR
2	3	111	Not covered unless the provider accepts assignment	CO, PI, or PR
3	3	242	Service not provided by network/primary care providers	CO, PI, or PR
4	3	243	Service not authorized by network/primary care providers	CO, PI, or PR
5	3	299	The billing provider is not eligible to receive payment for the service billed	CO, PI, or PR
6	2	284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	CO or PI
7	2	296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	CO or PI
8	3	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO, PI, or PR
9	3	51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	CO, PI, or PR
10	3	53	Services by an immediate relative or member of the same household are not covered.	CO, PI, or PR
11	3	119	Benefit maximum for this time period or occurrence has been reached.	CO, PI, or PR
12	3	149	Lifetime benefit maximum has been reached for this service/benefit category.	CO, PI, or PR
13	3	150	Payer deems the information submitted does not support this level of service.	CO, PI, or PR
14	3	166	These services were submitted after this payer's responsibility for processing claims under this plan ended.	CO, PI, or PR

CCTG Participants will have the opportunity to submit rationale in support of or not in support of addition of these proposed code combinations. Support for these proposed code combos will be gauged in a follow-up straw poll, alongside any other combinations identified for polling during the CCTG meeting. Timelines and instructions will be shared at a future date.

8. Next Steps

Results of the ISP and inclusions on the FSP will be discussed at the next CCTG meeting on: August 8th, 2023. Approved modifications will be included in the next CORE Code Combinations v3.7.5 October 2023.

9. Appendix

Table 6: Polled CBR Submissions

CARC #	CARC Description	RARC #	RARC Description	Type of Adjustment	% Support	# Abstentions	Key Comment Issues	Recommendation
Potential CORE-defined Business Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim								
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N887**	Providers not participating in the Medicare Advantage Plan have the right to appeal if the plan has partially or fully denied payment or if the provider believes the plan has not paid the services at the expected Medicare reimbursable rate or type of level/service. Providers may file their appeal in writing within 60 calendar days after the date of the remittance advice. For the plan to review the appeal, the plan will need a completed signed Waiver of Liability Statement. To obtain a Waiver of Liability form, please contact your Medicare Advantage Plan. Once we receive the completed forms, we will give you a decision on your appeal within 60 calendar days.	**Addition**	0%	3	• An SDO noted that they allow for the applicable technology to transmit data. • Three organizations stated their beliefs that RARC N887's description is more like an Alert and does not provide additional information regarding the CARC denial. • One organization expressed their belief that this combination does not fit under Business Scenario #2. • One organization expressed confusion at assigning a RARC referring the right to appeal to only certain CARCs and that this RARC may be applicable to other business scenarios and CARCs. • One organization noted that this seems like a generic denial combination. • One organization commented that this is a more of a generic denial combo. • Two organizations expressed their support for CORE's recommendation to not add this combination. One commented that RARC N887 does not pertain to a situation where additional data is needed from the billing provider.	**Do not add** proposed CAQH CORE Code Combination.
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided. Refer to the 835 Healthcare Policy Identification Segment if present.	**N880**	Original claim closed due to changes in submitted data. Adjustment claim will be processed under a new claim number.	**Addition**	50%	2	• One organization stated that this combination does not provide any additional information regarding the data that is missing or in error.	**Do not add** proposed CAQH CORE Code Combination.
129	Prior processing information appears incorrect. At least one Remark Code must be provided.			**Addition**	54%	2	• One organization commented that neither code combination directly sates that additional information is needed. They argue that N880 tells the provider that an action has been taken.	**Do not add** proposed CAQH CORE Code Combination.

CARC #	CARC Description	RARC #	RARC Description	Type of Adjustment	% Support	# Abstentions	Key Comment Issues	Reco.
Potential CORE-defined Business Scenario #3: Billed Service Not Covered by Health Plan								
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N887**	Providers not participating in the Medicare Advantage Plan have the right to appeal if the plan has partially or fully denied payment or if the provider believes the plan has not paid the services at the expected Medicare reimbursable rate or type of level/service. Providers may file their appeal in writing within 60 calendar days after the date of the remittance advice. For the plan to review the appeal, the plan will need a completed signed Waiver of Liability Statement. To obtain a Waiver of Liability form, please contact your Medicare Advantage Plan. Once we receive the completed forms, we will give you a decision on your appeal within 60 calendar days.	**Addition**	67%	3	• Two organizations stated that RARC N887 is, in their opinion, an alert as it does not provide additional information regarding the CARC adjustment/denial. • One organization noted that they disagree with the addition of CAGC PR for this combination.	**Add** proposed CAQH CORE Code Combination.
197	Precertification/authorization/notification/pre-treatment absent.			**Addition**	62%	3	• One organization noted that they disagree with the addition of CAGC PR for this combination.	**Do not add** proposed CAQH CORE Code Combination.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	**N881**	Client Obligation, patient responsibility for Home & Community Based Services.	**Addition**	85%	3	• One organization asked if the only CAGC used should be PR since it states, "client obligation" and "patient responsibility". • One organization noted that this RARC is very specific to Medicaid and is meant to be used with 142. This service would not fall under being a non-covered service.	**Add** proposed CAQH CORE Code Combination.

Table 7: Support for Proposed CBR Adjustments by Stakeholder Type

Proposed Code Combo	% Support	% Health Plans	% Providers	% Other
CARC 16/RARC N887	100%	54%	8%	38%
CARC 96/RARC N887	67%	50%	0%	50%
CARC 197/RARC N887	62%	45%	10%	45%
CARC 16/RARC N880	50%	86%	0%	14%
CARC 129/RARC N880	54%	75%	0%	26%
CARC 96/RARC N881	81%	55%	9%	36%

Table 8: Polled MBR Submissions

CARC #	CARC Description	RARC #	RARC Description	Type of Adjustment	% Support	# Abstentions	Key Comment Issues	Recommendation
CORE-defined Business Scenario #3: Billed Service Not Covered by Health Plan								
95	Plan procedure not followed.	**N79**	Service billed is not compatible with patient location information.	**Addition Type #3: Add RARC to an Existing CARC**	93%	2	• One organization expressed their lack of support for any code combinations with RARC N79 as it does not provide any additional information. They asserted that a better understanding and rationale of "patient location" is needed.	**Do add** proposed CAQH CORE Code Combination.
96	Non-covered charge(s).			**Addition Type #3: Add RARC to an Existing CARC**	79%	2	N/A	**Do add** proposed CAQH CORE Code Combination.
185	The rendering provider is not eligible to perform the service billed.	**N448**	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	**Addition Type #3: Add RARC to an Existing CARC**	85%	3	N/A	**Do add** proposed CAQH CORE Code Combination.

Table 9: Support for Adding New MBR Code Combinations by Stakeholder Type

Proposed Code Combo	% Support	% Health Plans	% Providers	% Other
CARC 95/RARC N79	93%	54%	8%	38%
CARC 96/RARC N79	79%	64%	0%	36%
CARC 185/RARC N448	85%	64%	0%	36%